Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-07-4116-01
Nestor Martinez, D.C. 6660 Airline Drive Houston, TX 77076	[redacted]
Respondent Name and Box #: Texas Mutual Insurance Co Rep Box #: 54	Insurance [redacted]

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary as taken from Table of Disputed Services: "Our facility is NOT required to obtain preauthorization within the first (2) weeks of a surgical intervention."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $877.70
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The UR nurse spoke with Angela and informed that the session/visit is limited to no more than an hour and no more than 4 CPT codes and no more than 45 minutes of cumulative time codes."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
11/13/06, 11/14/06, 11/16/06, 11/21/06, 11/22/06	97110	CAC-62, 930, CAC-W4, 891	1, 2, 3, 6	$358.60
11/13/06, 11/14/06, 11/16/06, 11/21/06, 11/22/06	97140	CAC-62, 930, CAC-W4, 891	1, 2, 4, 6	$333.30
11/13/06, 11/14/06, 11/16/06, 11/21/06, 11/22/06	97112	CAC-62, 930, CAC-W4, 891	1, 2, 5, 6	$185.80
Total Due:				$877.70

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "CAC-62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization" and "930 – Preauthorization required, reimbursement denied" and "CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration" and "891 – The insurance company is reducing or denying payment after reconsideration."
2. Per Rule 134.600 (c)(1)(B), the carrier is liable for all reasonable and necessary medical costs relating to health care that was preauthorized prior to providing the service. The Requestor provided a copy of a preauthorization letter dated 11-13-06 for (12) sessions of CPT codes 97110, 97140, and 97112.The Respondent references in their position statement that the verbal notification instructed limitations, however, the preauthorization written approval did not have any time limitations. Per Rule 134.600(j), the carrier shall send written notification of the approval or denial.
3. CPT Code 97110 has a MAR of $35.86 based on $28.69 x 125% x 2 units x 5 DOS = $358.60 due to Requestor per §134.202.
4. CPT Code 97140 has a MAR of $33.33 based on $26.66 x 125% x 2 units x 5 DOS = $333.30 due to Requestor per §134.202.
5. CPT Code 97112 has a MAR of $37.16 based on $29.73 x 125% x 1 unit x 5 DOS = $185.80 due to Requestor per §134.202.
6. Per review of Box 32 on CMS-1500, zip code 77076 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

A Legal and Enforcement referral has been made for inappropriate denial of the preauthorized services per Rule 134.600.

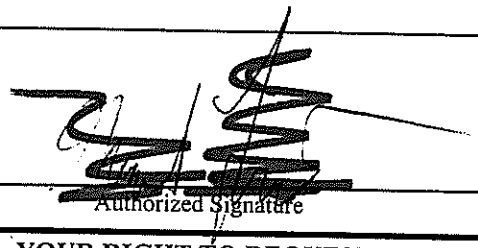
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202, Section. 134.600
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $877.70 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER



Authorized Signature | Medical Fee Dispute Resolution Officer | 10/24/07 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.